TheSource

Fall 2015

healthfirst®

IN THIS ISSUE

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Provider Services
1-888-801-1660
Monday–Friday, 9:00am–5:00pm

Fraud, Waste, & Abuse Anonymous Hotline
1-877-879-9137
Monday–Friday, 9:00am–5:00pm

Member Services: CHP, Medicaid
1-866-463-6743
Monday–Friday, 8:00am–6:00pm

Member Services: Medicare
1-888-260-1010
Monday–Friday, 8:00am–8:00pm

Produced by:
Healthfirst
Marketing and
Brand & Creative Strategy

From the desk of the
Chief Medical Officer

Dear Valued Provider:

Welcome to the Fall 2015 issue of *The Source*, Healthfirst's quarterly magazine, which provides valuable information to help you care for our members, stay up-to-date on key initiatives, and navigate claims and compliance issues.

As the healthcare market evolves, consumers are both becoming savvier and using online tools to review providers or facilities. Apart from the reputational pressure, member satisfaction is a factor in quality surveys like CAHPS, and satisfied patients are also more open to partnering with their providers on the journey to better health. On page 9, we offer some member-satisfaction best practices that you may find useful.

While member satisfaction is vital, we are also interested in the satisfaction of our participating providers. Healthfirst is launching a series of improvements to our provider websites that we believe will be beneficial to your practice. Please turn to page 16 to learn how you can offer your input.

In the previous issue of *The Source*, we alerted you to the arrival of ICD-10. This new standard went into effect on October 1, 2015, providing an expanded code set that allows for greater specificity in diagnosis and procedure codes. For more information about ICD-10 and what it means to your practice, please turn to page 3.

The fall also marks the launch of the annual Open Enrollment periods for Medicare and the Qualified Health Plans. This is an important time of the year for members who depend on these programs, and several of this issue's stories focus on our 2016 health plans.

Finally, I urge you to review *The Source* from cover to cover, as each issue offers information you can use, from tips that can improve your experience with our plan to clinical guidance that can help improve patient outcomes.

Thank you for the care you provide to our members, and for partnering with Healthfirst to improve the health and well-being of our communities.

Until next time,

Jay Schechtman, M.D., M.B.A.
Chief Medical Officer

Let us know what you think of ***The Source***. Send us an email at source@healthfirst.org.

ICD-10 Is Here!

As of **October 1, 2015**, the International Classification of Diseases, 10th Edition, or ICD-10, replaced ICD-9, the previous set of diagnosis and procedures codes.

As a provider, vendor, biller, or administrator, you need to ensure that your practice is billing with the appropriate ICD-10 codes.

Below are answers to some questions you might have about ICD-10 and how it impacts your practice.

What has changed with ICD-10?

ICD-10 uses 3–7 digits, up from the 3–5 digits used with ICD-9. As a result, ICD-10 allows for more detail and specificity in diagnosis and classification. These codes are used to identify symptoms and conditions, shorten patient chart information, note complaints and social circumstances, and more.

How are claims affected?

All claims submitted with dates of service (DOS) after **October 1, 2015**, must use ICD-10 codes. Combinations of ICD code versions must not be submitted together on a claim. This is very important, **as any claims submitted without the appropriate code versions will be denied**.

It is important to remember that providers are expected to utilize the appropriate ICD qualifier (Diagnosis Type Code within the ASC X12 v5010 standard). Healthfirst will use the ICD qualifier to distinguish between ICD-9 and ICD-10 code submissions. This means that if the qualifier indicates ICD-9, then the code must be a valid ICD-9 code; if the qualifier indicates ICD-10, then the code must be a valid ICD-10 code. Mixing the qualifiers and diagnosis codes will result in your claim being denied.

How can I avoid denials?

Ensure that you are coding correctly. All claims submitted with dates of service on and after **October 1, 2015**, must include only ICD-10 codes. Combinations of ICD code versions and/or qualifiers will result in denials.

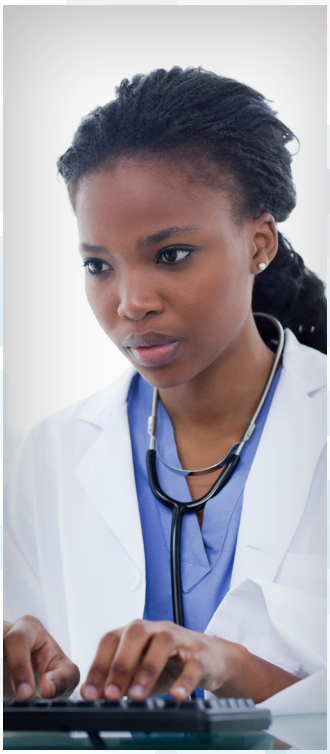
What happens if my claim does not have an ICD-10 code?

If your claim does not include a compliant ICD-10 diagnosis for dates of service beginning **October 1, 2015**, then your claim will be denied, with an explanation code stating "CLAIM DENIED: ICD-9 AFTER TRANSITION – ICD-10 REQUIRED." **It is critical that all provider types include compliant and appropriate diagnosis codes on all claims forms (i.e., paper and electronic) as of October 1, 2015**.

What happens if my claim is billed with an ICD-10 code date of service before October 1, 2015?

Claims for dates of services provided before **October 1, 2015**, must be billed with a compliant ICD-9 diagnosis. Your claim will be denied, with an explanation code stating "CLAIM DENIED: ICD-10 BEFORE TRANSITION – ICD-9 REQUIRED." A "corrected" claim will need to be submitted for reprocessing.

(Continued on page 4)



ICD-10 Is Here!

(Continued from page 3)

I'm a Mental Health Provider and use DSM tools for coding. How is ICD-10 related?

Version 5 of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released in May 2013 and took effect on January 1, 2014. As was the case with DSM-4, the codes within DSM-5 contain valid ICD-9 Clinical Modification (CM) codes that can be used to bill dates of service prior to **September 30, 2015**. Effective **October 1, 2015**, the ICD-10-CM codes are the official system that must be used. ICD-10-CM codes are already included in the DSM-5 and are listed in parentheses next to each disorder title. Simply use the codes listed in parentheses to code your diagnoses on health insurance claims for services rendered on and after the implementation date of **October 1, 2015**.

Does the ICD-10 conversion have an effect on provider reimbursement and contracting?

Possibly. We are evaluating the impact of ICD-10 on our contracting and clinical operations. The ICD-10 conversion is not intended to transform payment or reimbursement. However, it may result in reimbursement methodologies that more accurately reflect patient status and care.

What can physician practices and facilities do to ensure compliance with ICD-10?

The ICD-10 conversion affects nearly all provider systems and many processes. The largest impacts will likely be on clinical and financial documentation, billing, and coding. It is important that providers contact their billing or software vendor to understand their plans for conversion and testing.

What is Healthfirst's approach to mapping ICD-9 codes to the ICD-10 codes?

CMS has provided General Equivalency Mappings (GEMs) as an approach to define reasonable alternatives for mappings between ICD-9 and ICD-10 codes in both directions. While the GEMs provide guidance and a starting point for crosswalk development, there is currently no industry standard for mapping. As such, we have contracted with an industry-reputed vendor with ICD-10 expertise to assist us with fine-tuning the crosswalk between ICD-9 and ICD-10 for benefit design.

Where can I find more information?

Visit **www.healthfirst.org/ICD10** for tools and resources to help your practice during this transition, including a special edition of *The Source*, and links to educational videos and webinars.

Healthfirst offers an ICD-10-CM helpline to assist providers with (1) specific diagnostic coding needs and (2) how to align medical record documentation based on the ICD-10-CM level of specificity. We can be reached at **1-888-801-1660**. Selecting option 1 twice will connect you with an ICD-10-CM team member, or you can email us at **ICD10Inquiry@healthfirst.org**.

You may also visit the ICD10 page from the Centers for Medicare & Medicaid Services (CMS) at **www.cms.gov/ICD10**, where you'll find implementation guides, references, job aids, and General Equivalence Mappings (GEMS, also referred to as crosswalks), which provide information linking code versions.

Is Healthfirst using a crosswalk for claims processing?

No, we will not use a crosswalk for claims processing. Standard transactions with dates of service as of **October 1, 2015**, must be submitted with ICD-10 codes. After that date, we will process claims submitted with ICD-9 codes only for dates of service (outpatient) or dates of discharge (inpatient) prior to **October 1, 2015**.

What do I need to know about Healthfirst Medicare Plan benefits as we approach the 2016 plan year?

In the upcoming 2016 plan year, there will be a few changes to Healthfirst Medicare Plan benefits that may impact your patients. Some of these changes are outlined below*:

- **Prior authorization** through Healthfirst's Medical Management department is now required for *Physician Specialist/Other Healthcare Services*
- **Prior authorization** for *Occupational, Physical, and Speech therapy* must be obtained through Healthfirst's musculoskeletal vendor, **OrthoNet**, rather than through Healthfirst's Medical Management department
- There will now be a member copay of $35 for Urgently Needed Services (previously there was no copayment for most plans)
- The member copay for Emergency Services will increase from $65 (for most plans) to $75
- Most plans will still have a transportation benefit; however, transportation benefits are changing for the following plans in 2016:
  - 65+ — 12 one-way trips per year
  - CBP — 8 one-way trips per year
  - LIP — 16 one-way trips per year

The following are some additional changes to the Healthfirst 65 Plus Plan and the Coordinated Benefits Plan:

- There will now be a PCP copay of $10 (previously there was no copayment)
- The copay for specialist visits will increase from $30 to $35

As always, there is still a $0 copay for ALL Medicare-covered preventive exams (e.g., colorectal, cervical, prostate, and breast cancer screenings; diabetes screening; cardiovascular disease screening).

*This is not a comprehensive list. Member cost share may vary depending upon level of additional assistance, if applicable. For additional details, please visit our website at www.healthfirst.org/health-insurance/.

Healthfirst Expands Its Urgent Care Network

We have expanded the Urgent Care network that our members may access in the event of a non-life-threatening emergency or if the need for care arises when their doctor is unavailable. Urgent Care facilities offer a valuable service that can save members both time and money.

This exciting addition is just one of the ways in which we, through close provider relationships and strong community involvement, strive to meet the needs of the diverse communities we serve.

Flu Season Is Here

At Healthfirst, our members and their health come first. With flu season upon us, we know you share in our goal of protecting our members and their families from sickness.

Talk to your patients who are Healthfirst members about getting the flu vaccine. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccine for anyone over the age of six months. A flu vaccine is also especially important for pregnant women, adults over 65, and anyone with a chronic medical condition.

If the vaccine is not available at your office, please have the Healthfirst member call us so we can help them find their nearest location.

Medicare: 1-888-260-1010, 7 days a week, 8am–8pm
Medicaid: 1-866-463-6743, Monday–Friday, 8am–6pm
TTY: 1-888-542-3821 English/1-888-867-4132 Spanish (Español)

Additional resources for healthcare professionals—including key information about prevention, treatment, and diagnosis of the flu—and patient education tools for your practice are available at **www.cdc.gov/flu**.

FIVE KEY FACTS
About the New Essential Plan

Improving continuity of care for low-income New Yorkers

New in 2016, the Essential Plan (EP) is a federally funded insurance option for low-income, adult New Yorkers that offers comprehensive, high-quality care. Here's what you need to know about the new Essential Plan:

1 **EP will make it easier for you to ensure your patients get their recommended care.** The Essential Plan covers a larger portion of patient costs for routine care, including lower monthly premiums and copays. This will make it easier to ensure your cost-sensitive patients are not missing appointments or avoiding care altogether because of cost.

2 **EP will improve continuity of care for people whose incomes are near the level for Medicaid eligibility** (just over $16,000 for an individual per year, 138% Federal Poverty Level, or FPL). Previously, individuals whose incomes fluctuated during the year would be required to switch between a Qualified Health Plan (QHP) and Medicaid if they earned more or less than expected throughout the year. The EP bridges this gap, making it possible for eligible individuals to stay in a similar, low-cost plan, with a similar network all year.

3 **EP addresses the federal funding gap for documented, low-income immigrants who are not citizens.** Previously, documented immigrants could not be covered under federally funded Medicaid until they met a five-year residency requirement. During that five-year period, they were covered by New York State–funded Medicaid. Now, documented immigrants ages 21 to 64 can be covered through a federally funded EP. (To be eligible, these individuals must not have access to insurance from another source, such as through their employer or spouse.)

4 **EP will offer the same essential benefits as Healthfirst's Leaf Plans.** These covered benefits include preventive care, ambulatory care, behavioral health, prescription drugs, laboratory services, hospitalizations, and emergency care. For people earning above 138% FPL, adult vision and dental care will also be available with an additional premium. Documented immigrants earning less than 138% FPL will have access to additional benefits, including medical transportation, vision, and dental benefits.

5 **Open enrollment for the EP starts on November 1, 2015, and continues throughout the year,** with coverage effective January 1, 2016, for people who enroll by December 15.

Essential Plan for Low-Income New Yorkers: Eligibility and Monthly Price

Income	Immigration Status	2015 Eligibility	2016 Eligibility	Monthly Premium
Less than 138% of FPL	U.S. Citizens	Medicaid	Medicaid	$0
Less than 138% of FPL	Documented Immigrants	Medicaid	Essential Plan	$0
138%–150% of FPL	U.S. Citizens and Documented Immigrants	QHP	Essential Plan	$0 ($31 with vision and dental coverage)
150%–200% of FPL	U.S. Citizens and Documented Immigrants	QHP	Essential Plan	$20 ($46 with vision and dental coverage)

Leaf Premier Plans: Updates for 2016

Last year, Healthfirst introduced Leaf Premier Plans, Qualified Health Plans with coverage for adult vision and dental. These benefits helped make Healthfirst's Gold Leaf Premier and Silver Leaf Premier our most popular Qualified Health Plans in 2015.

In 2016, Healthfirst is adding new benefits to these two plans that will lower your patients' out-of-pocket costs for routine care and prescription drugs.

Your patients who are eligible for and choose a Gold or Silver Leaf Premier Plan will enjoy these new benefits in 2016:

- **Two additional no-cost primary care visits.** In addition to a no-cost wellness visit, your patients will now get two free primary care visits. For patients who avoid routine care during illness or follow-up care because of cost, this can help ensure they can get care when they need it.
- **Lower costs for prescriptions.** Your patients will pay only $3 for tier 1 generic drugs. This should make it easier for cost-sensitive patients to get their prescriptions.

All Healthfirst Leaf Plans will continue covering the ten essential health benefits, including preventive care, ER and urgent care, maternity care (including training in breast- or bottle-feeding, delivery, well-baby), and more. Your patients can learn more about the plans and see if they qualify for financial assistance at **www.hfplanfinder.org**.

You Can Help Healthfirst Eliminate Care Gaps

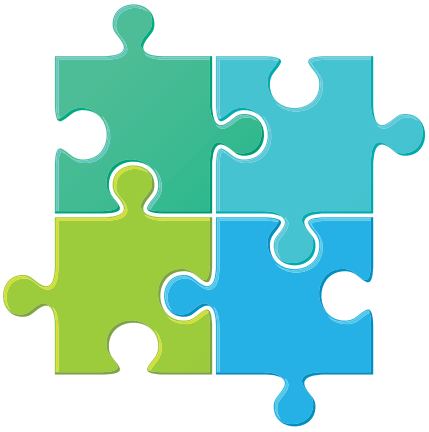
Reducing gaps in patient care is an important part of quality improvement. Find out how you can help ensure your patients are getting the care they need.

Helping your patients get their recommended services is a long-standing priority for both you and Healthfirst. However, it's not always clear which Healthfirst members have missed recommended care.

To address this challenge, Healthfirst has teamed up with Inovalon to identify members who've missed services, based on their claims data and patient profile. Inovalon mails the member a letter encouraging them to schedule an appointment and specifying which services are needed. In some cases, the patient may receive a home visit from a nurse practitioner or be asked to visit an Inovalon-run clinic.

However, closing care gaps often takes more than a letter to a patient—and that's where you come in! If you get a letter from Inovalon about patients who've missed recommended care, you can help by calling the member to remind them about recommended services and telling them why these services are important.

Your letter from Inovalon might also ask for additional information about a patient, such as a diagnosis. If so, please provide the requested details through the Inovalon portal at **https://epass.inovalon.com** (registration is required) or by fax at **1-866-682-6680**. Thanks for helping Healthfirst close gaps in member care.



PUZZLE PRACTICE
How Much Do You Know About Referrals?

Can you identify the six pieces of information that must be included in each referral submission for fast and smooth processing? Put your knowledge to the test!

1. ___ ___ ___gno___ ___ ___ code

2. ___a___ ___ of ___ ___ ___ ___ i___e range

3. N___ ___b___ ___ of ___n___ ___ (s)

4. Pr___ ___ ___ ___ ___ ___ ___ code

5. Your ___r___ ___ ___d___ ___ l___ ___u___ ___ ___r

6. The ___em___ ___r's ___D ___u___b___r

CORRECT ANSWERS:

1. Diagnosis code *(if there is more than one, then the primary should be added)* 2. Date of service range 3. Number of unit(s)
4. Procedure code 5. Your provider ID number 6. The member's ID number *(located on the member's Healthfirst insurance card)*

Please include all six pieces of information when submitting a referral. Taking the time to ensure that all the needed information is included will streamline the claims-processing experience and payment-turnaround times.

Doctor Look-up Tool is Available

Finding information about Healthfirst doctors is easy. Our Doctor Look-up Tool gives you and your patients detailed provider information—including weekend hours, office locations, and hospital affiliation—in an easy-to-use navigation.

Visit **www.HFDocFinder.org** to access the provider directory and learn more about these improvements.

Provider Manual

To review and download the most current Provider Manual, please visit **www.hfprovidermanual.org**.

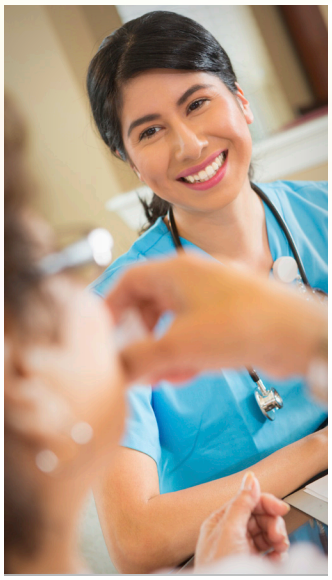
Quick Reference Guides

At Healthfirst, we are committed to providing our network with the tools needed to do business with us and to manage the health of our members. Our series of *Quick Reference Guides (QRGs)* for Medicaid, Commercial Plans, and Personal Care Agencies will help you easily access valuable information. The guides are available at **www.healthfirst.org/providers**.

Don't miss important alerts, notices, and coverage updates. Visit **www.healthfirst.org/alerts** regularly and stay informed.

Do we have your email address?
Don't miss important reminders and alerts. Visit us at **www.HFDocEmails.org** to sign up for email updates on information you need as a provider in the Healthfirst network.

Understanding Prescription Coverage to Improve Patient Satisfaction



Here is how patients evaluate their experience:

In the last six months, how often was it easy to use your health plan to get the medicines your doctor prescribed? (Always, Usually, Sometimes, Never)

How can you help improve the patient experience?

- **Help set expectations:** When members are prescribed medication, they expect it will be covered. If you are prescribing medication that isn't covered, be sure to help educate the members on what to expect when they get to the pharmacy.
- **Help take away the stigma attached to generic vs. name brand:** Often, members will save money with generics but will feel slighted if only generics are available. Provide them with the knowledge to understand the difference and make a choice.
- **Understand which prescriptions are covered:** When members know what to expect, they will find filling their prescriptions less burdensome and will have a better experience.

Are There Certain Drugs that Medicare Part D Will Not Cover?

Yes. By law, Medicare Part D can't pay for drugs when they would be covered under Medicare Part A or Medicare Part B. In order for a drug to be eligible for coverage under Medicare Part D, the drug must be: approved by the Food and Drug Administration (FDA) for safety and effectiveness; available only by prescription (over-the-counter drugs are not covered); used and sold in the United States; and used for a medically accepted indication. In addition, Medicare Part D excludes certain drugs or classes of drug which include:

- Drugs when used for weight loss or gain
- Drugs when used for treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- Drugs when used for symptomatic relief of cough and colds
- Nonprescription drugs
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Prescription vitamins and minerals, except prenatal vitamins and fluoride preparation products

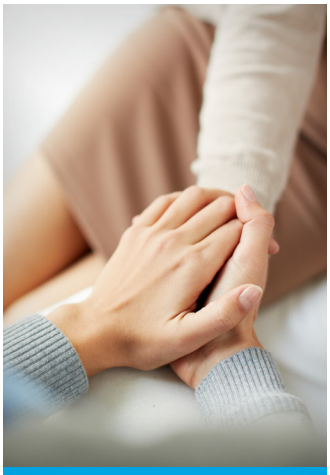
For a full list of medications covered under Healthfirst's Medicare Formulary, please view Healthfirst's website: **www.healthfirst.org/providers/provider-resources/?flp=319&slp=320**.

Why is Member Satisfaction Important?

Improving member satisfaction will help improve patient engagement and will increase your bottom line, patient retention, patient referrals, and incentives from Healthfirst. Member satisfaction is beneficial on all fronts.

Behavioral Health Update

Answers to your questions about the Healthfirst Personal Wellness Plan



As of October 1, 2015, all Healthfirst Medicaid members (including those who received behavioral health services through fee-for-service Medicaid) have behavioral health benefits through Healthfirst. This transition provides members with a complete Medicaid plan that covers medical, pharmacy, and now behavioral health services.

New York State has been working to create an environment where managed care plans, service providers, peers, families, and government partners work together to help patients prevent chronic health conditions, achieve personal health goals, and live healthier lives in their community. To achieve this goal, the New York State Department of Health (NYSDOH) is including behavioral health benefits in the full Medicaid package for Medicaid recipients. This includes Mental Health (MH) and Substance Use Disorder (SUD) services. In addition to the traditional benefits, the NYSDOH has included a special array of services designed to promote recovery in the community. These special benefits are called Behavioral Health Home and Community-Based Services (BH-HCBS). Below are answers to questions you might have about this transition and how it might impact your practice.

What is the Healthfirst Personal Wellness plan and how does it differ from the Medicaid plan?

The Healthfirst Personal Wellness plan is a Health and Recovery Plan (HARP) offered through Healthfirst. The State of New York and the Medicaid Office developed this program to better assist adults diagnosed with serious mental illnesses and substance use disorders in their recovery.

The Healthfirst Personal Wellness plan offers enhanced benefits that include an array of BH-HCBS. This plan provides opportunities for individuals to receive person-centered recovery services in their own community, with the same physical health benefits, pharmacy benefits, and newly carved-in behavioral health benefits covered under the Medicaid plan. In addition, this plan provides the opportunity for members to access an array of BH-HCBS designed to support recovery, optimal functioning, and overall improved health outcomes.

The Healthfirst Personal Wellness plan will have very specific eligibility guidelines and requirements. A member cannot attain a referral to join this plan. Eligible Medicaid members must be experiencing a serious mental illness or substance use disorder and be evaluated for eligibility by the state's enrollment broker before they can be enrolled into the plan. The State of New York will notify members and the health plan about eligibility.

When did the Behavioral Health benefit transition over to managed care?

As of October 1, 2015, all Healthfirst Medicaid members (including those who received behavioral health services through fee-for-service Medicaid) have behavioral health benefits through Healthfirst. This transition provides members with a complete Medicaid plan that covers medical, pharmacy, and now behavioral health services.

Who is eligible to receive Behavioral Health carve-in benefits?

All adults served in Medicaid Managed Care are eligible to use covered behavioral health services that include, but are not limited to, mental health and substance use treatment.

Will members lose their Medicaid benefits if they choose to stay in the Healthfirst Personal Wellness plan?

No. The Healthfirst Personal Wellness plan offers the same benefits and services covered under the Medicaid plan, as well as additional benefits (BH-HCBS) to support health and recovery.

Will members receive a new Healthfirst Member ID card if they transition to the Personal Wellness plan?

Yes. Healthfirst will send a new member ID card to members enrolled in the Personal Wellness plan.

How can providers verify member eligibility for the Healthfirst Personal Wellness plan?

Providers may verify a member's Healthfirst Personal Wellness plan eligibility by logging into the Healthfirst Secure Provider Portal, by calling Healthfirst Provider Services at **1-888-801-1660**, or by checking the member's Healthfirst Personal Wellness plan ID card.

Are Healthfirst Personal Wellness plan members required to be in a Health Home?

No. Health Home is a voluntary service. There is no requirement for a Healthfirst Personal Wellness plan member to enroll in a Health Home. It is in the member's best interest to join a Health Home and have access to a care manager in their community that can coordinate service delivery.

How will Health Homes work with Healthfirst case management staff to better service all of our Medicaid members?

Health Homes partner with Healthfirst, the member's providers, and their family to provide coordinated care that includes:

- the development of person-centered plans of care
- health promotion/coaching
- transitional-care management
- consumer and family support
- referral and connection to community and social support services

What new behavioral health benefits will be covered in the standard Medicaid Managed Care plan?

Behavioral health coverage and services in the standard Medicaid Managed Care plan will include:

- Inpatient Psychiatric
- Inpatient Drug & Alcohol (D&A)
- Intensive Psychiatric Rehabilitation Program (IPRT)
- Emergency Room
- Outpatient Mental Health Treatment
- Outpatient Drug & Alcohol (D&A)
- Detoxification
- Assertive Community Treatment (ACT)
- Personalized Recovery-Oriented Services (PROS)
- Continuing Day Treatment
- Partial Hospitalization
- Comprehensive Psychiatric Emergency Room (CPEP)
- Crisis Services
- Health Home
- Assessment

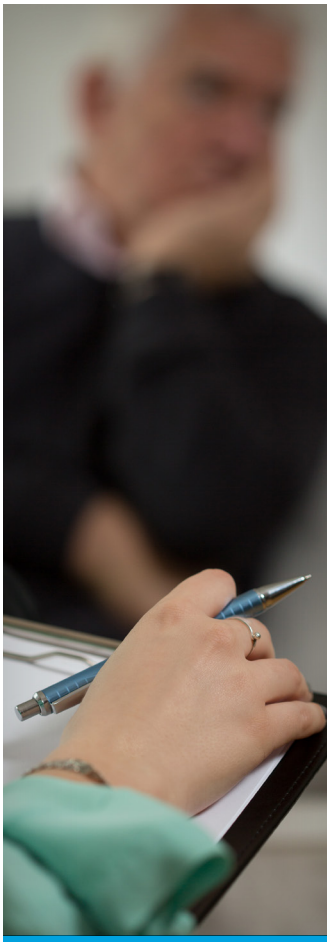
What coverage and services are offered in the Healthfirst Personal Wellness plan?

The services covered in the Personal Wellness plan are the same services covered in the standard Medicaid plan, plus additional BH-HCBS to support wellness and recovery. These additional services are listed below:

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Habilitation/Residential Support Services
- Family Support and Training
- Short-term Crisis Respite
- Intensive Crisis Respite (ICR)
- Education Support Services
- Empowerment Services – Peer Supports
- Nonmedical Transportation
- Prevocational Services
- Transitional Employment Support
- Intensive Supported Employment (ISE)
- Ongoing Supported Employment

Where can members go for additional resources?

New York State Department of Health – **www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/consumer_info/index.htm; www.omh.ny.gov/omhweb/bho/.**



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COMPLIANCECORNER

Healthfirst's Compliance Program is designed to reduce or eliminate fraud, abuse, and inefficiencies; to ensure Healthfirst's compliance with applicable regulations; and to reinforce Healthfirst's commitment to such activities.

Our goal is to provide you with important information and updates on compliance that are relevant to you. Compliance is an ever-changing environment, and the key to keeping up with those changes is communication. We always welcome feedback. You may email the Healthfirst Compliance and Audit department at **compliance@healthfirst.org** with your thoughts, questions, or suggestions.

IMPORTANT UPDATE for Healthfirst FDRs

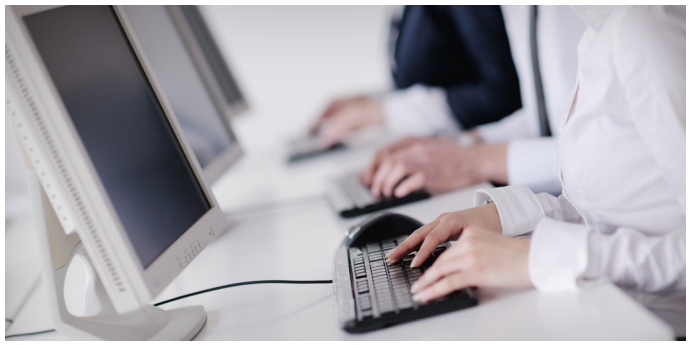
Healthfirst's commitment to compliance includes ensuring that our First Tier, Downstream, and Related Entities (FDRs) and Affiliates are in compliance with applicable state and federal regulations. We contract with you to provide administrative and healthcare services to our enrollees; we are ultimately responsible for fulfilling the terms and conditions of our contract with the Centers for Medicare and Medicaid Services (CMS) and for meeting the Medicare and Medicaid program requirements. Therefore, Healthfirst requires each FDR and Affiliate to comply with the Compliance requirements, including General Compliance, and Fraud, Waste, and Abuse (FWA) training.

As stated in the CMS memorandum dated June 17, 2015, as of **January 1, 2016**, CMS, to further minimize the administrative burden on Sponsors and FDRs, is broadening the availability of the CMS compliance program training. In doing so, CMS will no longer allow FDRs to modify the CMS training materials.

FDRs will have two (2) options for ensuring they have satisfied the general compliance and FWA training requirement that must be completed 90 days after initial hire/contracting and annually thereafter as described in the regulations and subregulatory guidelines.

1. An FDR and its employees can complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (see path below). Once the individual completes the training, the system will generate a certificate of completion.
2. FDRs may download, view, or print the content of the CMS standardized training modules from the CMS website to incorporate into their organization's existing compliance training materials/systems. The CMS training content **CANNOT** be modified to ensure the integrity and completeness of the training. However, an organization can add to the CMS training to cover topics specific to their organization.

Training materials are available at the following path: **www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html**.



To ensure compliance, Healthfirst requires each FDR to complete a Compliance Attestation upon contract and annually thereafter via the FDR website **www.healthfirstFDR.org**. As of **January 1, 2016**, Healthfirst, to be in compliance with the CMS regulation, will no longer provide the option for FDRs to utilize their own training. The attestation for General Compliance/Fraud, Waste, and Abuse training will include the options noted below:

- My organization has fulfilled the FWA training requirement via the CMS Fraud, Waste, and Abuse (FWA) training. All employees and contractors have completed this FWA training within 90 days of hire/contract and annually thereafter.
- My organization is "deemed" to have met the FWA training requirement through enrollment into Part A or B of the Medicare program or through accreditation as the supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

If at any time there are questions or concerns regarding FDR requirements, please contact **Compliance@healthfirst.org**.

If you suspect a case of fraud, waste, abuse, or other violations of company policy, you can report it by:

- Calling the toll-free Confidential Compliance Hotline at **1-877-879-9137**
- Filing a report via the Confidential Website Address: **www.hfcompliance.ethicspoint.com**

Learn more at **www.healthfirst.org/providers/compliance**.

Statin Adherence—How You Can Help

When taken correctly, statins are highly effective drugs that help to lower LDL cholesterol and decrease cardiovascular risk. It's been estimated, however, that about half of patients prescribed statin therapy discontinue within the first year, and that adherence continues to decrease with time.

Some of the most common causes of discontinuation are side effects, low health literacy, and lack of education around the disease state, and cost of medication. It's important to educate your patients on the health benefits of statins and what they can expect while taking their medication. Here are some talking points you can incorporate into your discussion with your patients:

Does high cholesterol have symptoms?

High cholesterol levels usually won't produce any symptoms, but the higher your blood cholesterol level, the greater your risk for developing heart disease or having a heart attack. When there is too much cholesterol in your blood, it builds up on the walls of your arteries. This can slow down or block the flow of oxygen-rich blood to the heart and cause chest pain, which is the key warning sign of a heart attack.

How can statins help your cholesterol?

Statins lower the amount of cholesterol made in your liver. These medicines lower bad cholesterol levels and raise good cholesterol levels. They can also help slow the build-up of plaque in your arteries. Statins help manage, but do not "cure," high cholesterol. Keep taking your medicine to keep your cholesterol level in the range advised by your doctor.

What else should you know about statins?

Statins can cause many side effects, including serious muscle problems. Some statins are not safe to take with other medicines or with grapefruit or grapefruit juice. You may have fewer side effects with one statin than another. Talk to your doctor if you feel you are having side effects or any unusual problems while taking this medicine.

Don't forget to check the formulary before you prescribe a statin! Please visit the Provider Resources section on our website to find all of our formularies: **www.healthfirst.org/formulary**.

CLINICAL

Smoking Cessation

The impact of smoking, especially for those with chronic illness, is known and staggering. Currently, there are 46.6 million smokers in the U.S., where tobacco use is still the leading preventable cause of death.

The prevalence of tobacco use among adult Medicaid members is about 30%, and as high as 40% among some blue-collar groups. Effective treatments are available but not always utilized. For many health plans, including Medicare and Medicaid, counseling patients to quit smoking is a reimbursable service.

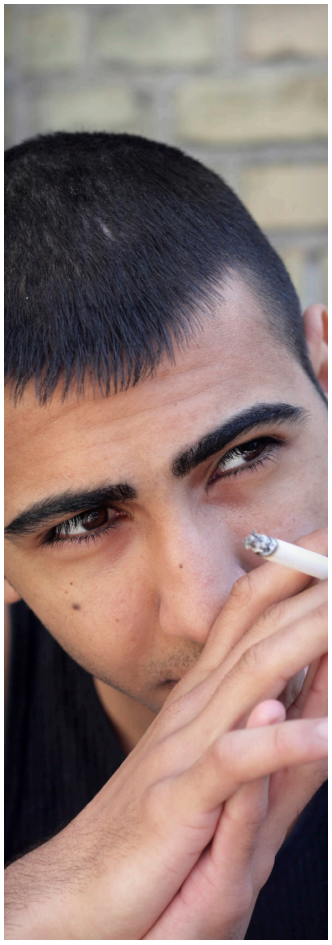
- 70% of smokers want to quit
- 40% try to quit each year
- Only 2% call state or national quit lines

Physicians are advising most, but not all, of their patients to quit smoking, but we are missing opportunities to provide discussion of smoking-cessation strategies or medications. The Affordable Care Act calls for health plan coverage for interventions rated "A" by the Preventive Services Task Force, and smoking-cessation counseling by physicians meets that standard. Medicare already pays for smoking-cessation counseling, and twenty-two states—New York among them—reimburse some forms of counseling.[1]

While physicians may consider as best candidates for tobacco dependence treatment only those who admit a readiness to quit, only a minority of tobacco users at any time will make that admission. And the selection of treatment candidates based on other health conditions has been ineffective in promoting smoking-cessation treatment for the millions of people who will benefit.[2]

The National Lung Screening Trial (NLST) reviewed clinician-reported delivery of the 5As (ask, advise, assess, assist, and arrange [follow up]) after lung screening to determine if there was an association with smoking behavior changes among patients. In this matched case-control study of more than 3,000 smokers (in the first year after the participants' initial screens), the 5A rates were as follows:

- Ask—77.2%
- Advise—75.6%
- Assess—63.4%
- Assist—56.4%
- Arrange (follow-up)—10.4%



SPOTLIGHT

The authors found that providers were less likely to deliver assistance with quitting, and much less likely to arrange for follow-up, yet those smokers receiving the delivery of "assist (with quitting)" or "arrange (follow-up)" were significantly more likely to quit.[3]

This study affirms and confirms the value of primary care intervention for patients who smoke, but it raises the concern that the proven intervention is offered only to a limited number of patients, and in a manner that is often inconsistent and incomplete.

Many Healthfirst members in your care face socioeconomic challenges that can impact optimal health outcomes; yet this need not be true for tobacco-dependence treatment.[4] But for ALL Healthfirst members who use tobacco, smoking cessation is vital to longevity, quality of life, and improved health outcomes.

What does this mean for you?

- Healthfirst recommends that you implement an "opt-out" approach to smoking cessation.
- Ask every adolescent and adult patient about tobacco use and dependence.
- If your patient is using tobacco, initiate the "5As" for all.

CLINICAL GUIDELINES	
ASK	Ask the patient about tobacco use at every visit, and document the response.
ADVISE	Advise the patient to quit in a clear and personalized manner.
ASSESS	Assess the patient's willingness to make a quit attempt at this time.
ASSIST	Assist the patient to set a quit date and make a quit plan; offer medication as needed.
ARRANGE	Arrange to follow up with the patient within the first week, either in person or by phone, and take appropriate action to assist them.

- Focus on key areas of impact:
  - **ASSIST** your patients by talking about quitting, recommending use of stop-smoking medications, and/or recommending stop-smoking counseling;
  - **ARRANGE** follow-up for counseling and support, either in your office or by use of the New York State (NYS) Smokers' Quitline (**1-866-697-8487** or **www.nysmokefree.com**); and
  - **REMEMBER** to follow up at every visit to show your support for the tough journey that your patient who smokes must follow until they successfully cease tobacco use.

Making tobacco-dependence treatment a cornerstone of your prevention and management care plan for your patients is of proven benefit to the improvement of outcomes, including longevity.

(Continued on page 16)

Sources:

[1] www.nysmokefree.com/download/MedicaidMedicareHighlights.pdf. Accessed 7/22/15.

[2] Richter, Kimber P. and Edward F. Ellerbeck. "It's Time to Change the Default for Tobacco Treatment." Addiction 110.3 (2014): 381–386. Web.

[3] Park, Elyse R. et al. "Primary Care Provider-Delivered Smoking Cessation Interventions and Smoking Cessation Among Participants in the National Lung Screening Trial." JAMA Internal Medicine JAMA Intern Med (2015): n. pag. Web.

[4] Evans, S. and C.E. Sheffer. "The Process of Adapting the Evidence-Based Treatment for Tobacco Dependence for Smokers of Lower Socioeconomic Status." J Addict Res Ther Journal of Addiction Research & Therapy 06.01 (2015): n. pag. Web.

CLINICAL SPOTLIGHT

(Continued from page 15)

2015 Smoking Cessation Performance Improvement Project

The Centers for Disease Control and Prevention (CDC) reports that New York had nearly 2.6 million smokers in 2004 and had 25,000 residents die due to cigarette use which resulted in an average loss of 14 years of life for each individual.[5] The annual healthcare costs in New York State directly caused by smoking are estimated to be $10.39 billion.[6]

In an effort to improve the health outcomes of our 18- to 64-year-old Medicaid enrollees who smoke, and to fulfill a two-year Performance Improvement Project (PIP) required by the New York State Department of Health (NYSDOH), Healthfirst is implementing a project designed to improve the identification of smokers and increase the utilization of smoking-cessation benefits (counseling and/or medication) for smokers through the following interventions:

- **Enhanced internal processes** to identify members who smoke and wish to quit.
- **Member education** on the hazards of smoking, effective strategies on how to quit, online/community resources, Medicaid smoking-cessation benefits, and the NYS Quitline.
- **Facilitated member referrals** by Healthfirst staff to the New York State (NYS) Quitline for telephone counseling support, smoking-cessation benefit education, and a free Nicotine Replacement Therapy (NRT) starter kit.
- **Smoking cessation promotion** in newsletters/websites and in the community during Healthfirst's Health & Wellness Expos and at American Diabetes Association (ADA)–sponsored events.
- **Provider reinforcement** of the smoking-cessation clinical guidelines.
- **Provider education** on best practices regarding smoking assessment and treatment, Medicaid smoking-cessation benefits, and the appropriate smoking-cessation counseling codes.
- **Collaboration** with the NYS Quitline and NYC Treats Tobacco for online referral access and provider education, respectively.

Our aims are to improve the identification of Healthfirst's Medicaid smokers and the referrals to the NYS Quitline by 5%, as well as to increase the utilization of smoking-cessation benefits (i.e., counseling and/or medication) by 3%. The PIP initiatives are all on target and will continue to be reported to the NYSDOH on a quarterly basis until the study closes on 12/31/16.

For more information on smoking-cessation clinical guidelines, tools, member-education materials, and resources, please visit **www.healthfirst.org**.

Sources:

[5] Centers for Disease Control and Prevention (CDC). 2002. "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995–1999." Morbidity and Mortality Weekly Report 51(14):300–303.

[6] Campaign for Tobacco-Free Kids. Fact Sheet: The Toll of Tobacco in New York. June 20, 2014.

We want to hear from you!

You can help Healthfirst offer a better online experience by telling us about your needs and your practice.

Healthfirst is launching a series of improvements to our provider websites to make it easier for you to get the information you need. To ensure the best results, we want to know how you use the site, what's working well, and what needs to be improved.

Give your input in these two surveys:

- Website survey: Visitors to Healthfirst's provider website will be asked to complete a survey before leaving the site.
- Email survey: Members of Healthfirst's mailing list will get a survey by email. If you're not already signed up for updates from Healthfirst, visit **www.Hfdocemails.org** to get started!

Don't miss your chance to let your voice be heard about the Healthfirst website. Your feedback will be taken into consideration during the web redesign process over the next year. Be on the lookout for more opportunities to give feedback in the coming months. Thanks for helping us improve.

Healthfirst Joins Medical Mission to Haiti

As part of an ongoing collaboration with Healthfirst, the National Organization for the Advancement of Haitians (NOAH N.Y.) and the Haitian American Alliance of New York, Inc. (HAA) led a Humanitarian Medical Mission from June 26 to July 5 in the town of Fort-Liberté, Haiti.

This year, almost 70 volunteers, including translators, doctors, nurses, dentists, hygienists, pharmacists, and medical students, donated their time to assist with this annual humanitarian mission. Bringing much-needed medical resources, including more than 50 bags of medical, surgical, dental, and pharmaceutical supplies, they assisted with patient triage, translation, health screenings/assessments, and dental and clinical surgeries.

During the week-long mission, this team of volunteers—including Healthfirst's Susan Beane, M.D., Vice President and Medical Director; George Hulse, Vice President, Community Engagement; and Errol Pierre, Vice President, Medicaid and Commercial Market—worked out of the Fort-Liberté Hospital to offer pediatric, geriatric, and internal medicine services to residents in need. They took temperatures and vitals and distributed prescriptions and vitamins. Mild to moderate surgeries were staged in an operating room organized for this purpose. Our team of volunteers provided patient care and support to the surgeries performed. During the time spent at Fort-Liberté Hospital, our team also assisted with the delivery of a baby boy.

This year, almost 70 volunteers, including translators, doctors, nurses, dentists, hygienists, pharmacists, and medical students, donated their time to assist with this annual humanitarian mission.

In addition, a mobile team drove to nearby rural towns, bringing free medical care to hundreds of residents living in Ouanaminthe who do not have the means or the resources to travel to the hospital. They also helped prepare for the grand opening of a new health center in Caracol. Once it is fully operational, the health center will offer medical, ob/gyn, dental, physical therapy, and pharmacy services.

You may visit **www.noahny.org** for additional information on this annual humanitarian mission.

Fort-Liberté has a very rich history. Known as one of Haiti's oldest cities, it is the site where Haiti issued its preliminary proclamation of independence on November 29, 1803. This marked the first-ever successful slave army revolution of the colonial era. The city's population is approximately 11,500, a figure that represents only a small portion of the country's total population of 10 million, the majority of whom are concentrated in the capital city of Port-au-Prince and its environs. The Haitian culture is a hybrid of French and African elements, with a flare of Spanish influence from the country's neighbor, the Dominican Republic.

Falls in Older Adults

Falls are the leading cause of injury-related deaths, hospitalizations, and emergency department visits among adults 65 and older. Falls can result in lasting, serious consequences that affect mobility, independence, and mental health. Falls are not accidents! They are not random, uncontrollable acts of fate, but occur in predictable patterns, with recognizable risk factors and among identifiable populations. A fall is a predictable and preventable event.

Who is at Risk?

- Males have a higher risk of death due to falls
- Females have a higher risk of hip fracture due to falls
- Aging increases the risk of falling and the severity of a fall injury
- People who have previously fallen are at an increased risk of falling again
- People who suffer from sleep disturbances are at an increased risk of falling

What Conditions Increase the Risk of Falling?

- Leg weakness is associated with a fourfold increase in the risk of falling
- Problems with gait and balance are associated with a threefold increase in the risk of falling
- Vision impairment increases the risk of falling by 2.5 times
- Chronic conditions such as Parkinson's disease, stroke, arthritis, osteoporosis, and incontinence increase the risk of falling
- A fear of falling leads to loss of confidence, an avoidance of physical activity, an increased functional decline, and ultimately an increased risk of falling
- Taking four or more medications puts older adults at risk of falling

Where is the Risk?

- 60% of fall-related hospitalizations in older adults originate in the home
- 36% of fall-related ED visits in older adults originate in the home

Home Hazards Include:

- Clutter in walkways and on stairs
- Slippery or inconsistent flooring surfaces
- Unstable furniture
- Poor/inadequate lighting
- Pets and pet-related objects
- Lack of stair railings or grab bars
- Lack of easy-access bathrooms

Ask your patients if they've experienced the following in the last three months or since they last saw a doctor:

- A fall or a near fall (slip or trip)
- Problems with walking or balance
- Muscle weakness (especially in the legs)
- Loss of feeling, or numbness, in your legs or feet
- Swelling in your ankles or feet
- Difficulty breathing or shortness of breath
- Dizzy or lightheaded, passed out or fainted
- Changes in hearing or vision
- Changes in sleep pattern
- Chronic conditions like diabetes, arthritis, or high/low blood pressure
- Felt depressed for an extended period of time
- A fear of falling
- Problems doing daily activities at home (such as bathing or getting dressed)
- Other conditions

Prevention Strategies What reduces the risk of falling?

- Medication review
- Home assessments with modification
- Exercise
- Annual vision exams

Web resources include:

- **www.health.ny.gov/prevention/injury_prevention/;**
- **www.cdc.gov/ncipc/duip/preventadultfalls.htm.**

Source:
www.health.ny.gov/prevention/injury_prevention/falls_in_older_adults_nys.htm

Caring for Our Young Members

Another school year has started. Parents will be making appointments with you for their children's back-to-school checkups and immunizations. This is your opportunity to ensure that our young members receive the preventive and chronic care they need.

In order to maintain the health and well-being of our children, Healthfirst encourages you to follow the clinical guidelines listed below during each visit:

GUIDELINE	0–15 MTHS OLD	2 YO	3 YO	4 YO	5 YO	6 YO	8 YO	10 YO	11–14 YO	15–17 YO	18–21 YO
Dental visit		X	X	X	X	X	X	X	X	X	X
Well-child visit	At least 6 visits	X	X	X	X	X	X	X	X	X	X
Lead screening	X	X									
Childhood immunizations (4-DTaP, 3-IPV, 3-Hep B, 2-Influenza, 3-Hib, 4-PCV, 1-MMR or 1-Measles & Rubella or 1-Mumps or 1-Rubella, 2 or 3-Rotavirus, 1-Hep A, and 1-VZV)	X	X									
Adolescent immunizations (1-Meningococcal, 1-Tdap or 1-Td or 1-Tetanus, and 1-Diptheria)									On or before 13th birthday		
HPV vaccine (3 Doses)									On or before 13th birthday		
BMI screening/counseling for nutrition & physical activity			X	X	X	X	X	X	X	X	
Assess, educate, and counsel on sexual activity, depression, tobacco usage, and substance abuse									Start at age 12	X	
Update asthma action plan					X	X	X	X	X	X	X

For more information, please go to **www.healthfirst.org** to obtain tools, member educational materials, and resources.

2015 Clinical Practice Guidelines

The 2015 Healthfirst Clinical Practice Guidelines (CPG) are available on our provider site at **www.healthfirst.org/providers/provider-resources**. These evidence-based peer review guidelines cover both routine and complex conditions.

Asthma Management

In 2011, there were approximately 1.4 million New York adults diagnosed with asthma.[1] The prevalence for children ages 0–17 was 10.4% (an estimated 456,000 children) during 2006–2010.[2] There were more than 160,000 emergency department visits and in excess of 38,000 hospitalizations per year due to asthma during 2009–2011. According to the *New York State Asthma Surveillance Summary Report* (October 2013), more than $276 million dollars were spent in 2010 for asthma-related services—the average cost per Medicaid enrollee with asthma was $1,109.

These staggering statistics reveal that asthma is a major public health problem for many New Yorkers. You can help our Healthfirst members improve their health outcomes by educating them on the appropriate use of their medications and following the stepwise approach recommended by the *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma [EPR-3]* for long-term asthma management.

- **Long-term Controllers (Inhaled Corticosteroids, Long-acting Beta2 Agonists, Leukotriene Modifiers)** are taken daily over a long period and are used to relax airway muscles and to improve symptoms and lung function
- **Quick-relief or "Rescue" Medications (Short-acting Beta2 Agonists)** are used in acute episodes

When treating our Healthfirst members with persistent asthma, please ensure that they are prescribed at least one prescription for a long-term controller medication and that they remain on it for at least 75% of the treatment period. Before prescribing a medication, check the provider website listed below to confirm that it is on Healthfirst's formulary.

Visit **www.healthfirst.org** for additional tools, formulary, clinical guidelines, and educational resources on asthma.

Sources:

[1] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS) Prevalence Data. Available from: **www.cdc.gov/asthma/brfss/default.htm#09** [Last accessed: April 8, 2013].

[2] New York State Behavioral Risk Factor Surveillance System, Asthma Call-Back Survey data, 2006–2009.

STEPWISE APPROACH FOR MANAGING ASTHMA LONG TERM

The stepwise approach tailors the selection of medication to the level of asthma severity (see page 5) or asthma control (see page 6). The stepwise approach is meant to help, not replace, the clinical decisionmaking needed to meet individual patient needs.

ASSESS CONTROL:

STEP UP IF NEEDED (first, check medication adherence, inhaler technique, environmental control, and comorbidities)

STEP DOWN IF POSSIBLE (and asthma is well controlled for at least 3 months)

At each step: Patient education, environmental control, and management of comorbidities

0–4 years of age

	Intermittent Asthma	Persistent Asthma: Daily Medication Consult with asthma specialist if step 3 care or higher is required. Consider consultation at step 2.				
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Preferred Treatment†	SABA* as needed	low-dose ICS*	medium-dose ICS*	medium-dose ICS* + either LABA* or montelukast	high-dose ICS* + either LABA* or montelukast	high-dose ICS* + either LABA* or montelukast + oral corticosteroids
Alternative Treatment†,‡		cromolyn or montelukast				
	If clear benefit is not observed in 4–6 weeks, and medication technique and adherence are satisfactory, consider adjusting therapy or alternate diagnoses.					
Quick-Relief Medication	▪ SABA* as needed for symptoms; intensity of treatment depends on severity of symptoms. ▪ With viral respiratory symptoms: SABA every 4–6 hours up to 24 hours (longer with physician consult). Consider short course of oral systemic corticosteroids if asthma exacerbation is severe or patient has history of severe exacerbations. ▪ Caution: Frequent use of SABA may indicate the need to step up treatment.					

5–11 years of age

	Intermittent Asthma	Persistent Asthma: Daily Medication Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.				
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Preferred Treatment†	SABA* as needed	low-dose ICS*	low-dose ICS* + either LABA,* LTRA,* or theophylline(b) **OR** medium-dose ICS	medium-dose ICS* + LABA*	high-dose ICS* + LABA*	high-dose ICS* + LABA* + oral corticosteroids
Alternative Treatment†,‡		cromolyn, LTRA,* or theophylline§		medium-dose ICS* + either LTRA* or theophylline§	high-dose ICS* + either LTRA* or theophylline§	high-dose ICS* + either LTRA* or theophylline§ + oral corticosteroids
		Consider subcutaneous allergen immunotherapy for patients who have persistent, allergic asthma.**				
Quick-Relief Medication	▪ SABA* as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments every 20 minutes as needed. Short course of oral systemic corticosteroids may be needed. ▪ Caution: Increasing use of SABA or use >2 days/week for symptom relief (not to prevent EIB*) generally indicates inadequate control and the need to step up treatment.					

≥12 years of age

	Intermittent Asthma	Persistent Asthma: Daily Medication Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.				
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Preferred Treatment†	SABA* as needed	low-dose ICS*	low-dose ICS* + LABA* **OR** medium-dose ICS*	medium-dose ICS* + LABA*	high-dose ICS* + LABA* **AND** consider omalizumab for patients who have allergies††	high-dose ICS* + LABA* + oral corticosteroid§§ **AND** consider omalizumab for patients who have allergies††
Alternative Treatment†,‡		cromolyn, LTRA,* or theophylline§	low-dose ICS* + either LTRA,* theophylline,§ or zileuton‡‡	medium-dose ICS* + either LTRA,* theophylline,§ or zileuton‡‡		
		Consider subcutaneous allergen immunotherapy for patients who have persistent, allergic asthma.**				
Quick-Relief Medication	▪ SABA* as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments every 20 minutes as needed. Short course of oral systemic corticosteroids may be needed. ▪ Caution: Use of SABA >2 days/week for symptom relief (not to prevent EIB*) generally indicates inadequate control and the need to step up treatment.					

* **Abbreviations:** EIB, exercise-induced bronchospasm; ICS, inhaled corticosteroid; LABA, inhaled long-acting beta$_2$-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta$_2$-agonist.
† Treatment options are listed in alphabetical order, if more than one.
‡ If alternative treatment is used and response is inadequate, discontinue and use preferred treatment before stepping up.
§ Theophylline is a less desirable alternative because of the need to monitor serum concentration levels.
** Based on evidence for dust mites, animal dander, and pollen; evidence is weak or lacking for molds and cockroaches. Evidence is strongest for immunotherapy with single allergens. The role of allergy in asthma is greater in children than in adults.
†† Clinicians who administer immunotherapy or omalizumab should be prepared to treat anaphylaxis that may occur.
‡‡ Zileuton is less desirable because of limited studies as adjunctive therapy and the need to monitor liver function.
§§ Before oral corticosteroids are introduced, a trial of high-dose ICS + LABA + either LTRA, theophylline, or zileuton, may be considered, although this approach has not been studied in clinical trials.

Quick Guide to Contraception

For Clinicians in any Specialty

Contraception is safe and easy to provide. It carries fewer health risks than pregnancy, and nearly all women can use most methods. Helping patients choose an appropriate method is not complicated. Most women, including adolescents, need only a focused history, a blood pressure check, and minimal follow-up to begin contraception.

Contraception can start today. "Quick Start" is the preferred, simple way to start contraception at today's office visit. Pelvic exams and Pap tests are not required.

Use Quick Start to Initiate Contraception Today

Quick Start can be used for any contraceptive method.

It does NOT require a pelvic exam, Pap test, complete physical exam or lab tests.

First day of LMP < 5 days ago?

YES → **Initiate contraception today.**

NO → **Do a urine pregnancy test. If result is negative:**

1. **Initiate contraception today.**
2. **Advise condom use for one week as back-up.**
3. **Provide EC if patient has had unprotected sex in the past 5 days.** ***(See page 12.)***

- **Urge condom use to protect against HIV and other STIs.**
- **Provide at least a 3-month supply of pills, rings, or patches.**
- **Patient should return for pregnancy test:**
  - **3 weeks after starting DMPA**
  - **3 weeks after starting an extended cycle pill**
  - **If no period at the end of first pill, patch, or ring cycle**

This Quick Guide provides simple, state-of-the-art guidelines for busy clinicians in ANY specialty on how to:

1. Routinely assess the reproductive health needs of all patients—including adolescents.
2. Prescribe appropriate contraception, including emergency contraception, to all women—including adolescents.
3. Provide appropriate contraception immediately after an induced or spontaneous abortion.

Additional resources are available at **www.nyc.gov/html/doh/downloads/pdf/ms/contra-guide.pdf** and **www.nyc.gov/html/doh/html/hcp/sexual-provider.shtml**.

PRENATAL CARE

Several major risk factors are associated with poor pregnancy outcomes, including low birth weight and infant mortality (deaths). Some of these risk factors include late or no prenatal care, cigarette smoking, alcohol and other drug use, being HIV positive, spacing of pregnancies, maternal age, poor nutrition, and socioeconomic status. Minority women are more likely to have poorer birth outcomes than the general population.

New York State is committed to addressing risk factors that lead to poor birth outcomes, especially in the hard-to-reach populations of the state. This is evidenced by the improvement in the infant mortality rates over the past few years. Infant mortality in New York State has decreased by more than 34.3% over the past 10 years, taking the state from 32nd in the nation to ninth. Nationally, the decline over the same period was 21.7%.

Even though great strides have been made in addressing the needs of women and children in the state, New York continues to make the health of women and children a priority. Several programs have been developed with the purpose of increasing access to prenatal and perinatal care. The mission of these programs is: **"To improve the health of underserved women, infants, and children through improved access to and enhanced utilization of perinatal and prenatal care and related services."**

The New York State Department of Health promotes the health of child-bearing, pregnant, and postpartum women, and of newborns, through the following programs:

Growing Up Healthy Hotline

This toll-free hotline **(1-800-522-5006)** operates 24 hours a day, seven days a week and provides information and referral for individuals, including teens, about pregnancy care services, family planning, healthcare, nutrition, and other health and human services. Information is available in English, Spanish, and many other languages.

New York State Perinatal Quality Collaborative (NYSPQC)

The NYSPQC, an initiative of the NYSDOH, aims to provide the best and safest care for women and infants in New York State by preventing and minimizing harm through the use of evidence-based practice interventions. This is achieved through a collaborative approach where all participating hospital teams focus on specific health outcomes and learn from one another. Approximately 100 birthing hospitals across New York State are currently participating in one or more of the NYSPQC projects.

Perinatal Regionalization Program

Perinatal regionalization ensures that there are hospitals that can provide a full range of services for pregnant women and their babies in a geographic region. This means parents-to-be can be sure that there are hospitals near where they live that can provide everything from a basic, uncomplicated delivery to those that can serve mothers and babies with the most complex, critical problems.

Breastfeeding Promotion Program

The program provides training and guidelines to help get more mothers to breastfeed and to get them to breastfeed longer.

Source:
www.health.ny.gov/community/pregnancy/health_care/prenatal/

Postpartum Care

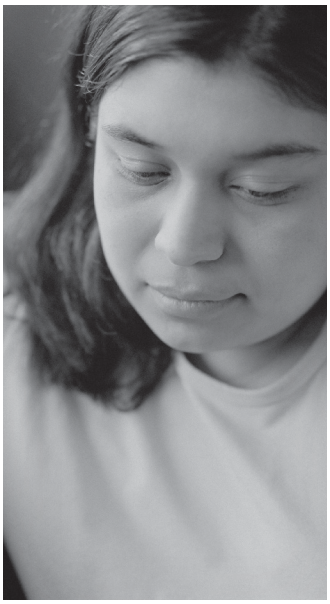
Providers are reminded to document postpartum care in the medical record.

Postpartum visit to an OB/GYN practitioner or midwife, family practitioner, or other PCP on the 21st day, or between 21 and 56 days, after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam.
- Evaluation of weight, BP, breasts, and abdomen.
  - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
- Notation of postpartum care, including, but not limited to:
  - Notation of "postpartum care," "PP care," "PP check," "six-week check."
  - A preprinted "Postpartum Care" form in which information was documented during the visit.

Don't forget—remind the new mom to enroll her newborn with Healthfirst within 60 days after birth to ensure continuous coverage for the baby.

Source:
HEDIS 2016 Volume 2 Technical Specifications



Postpartum Depression

Many women have the baby blues after childbirth. If your patients have the baby blues, they may have mood swings, feel sad, anxious or overwhelmed, have crying spells, loss of appetite, or have trouble sleeping. The baby blues most often go away within a few days or a week. The symptoms are not severe and do not need treatment.

The symptoms of postpartum depression last longer and are more severe. The mother may also feel hopeless and worthless, and may lose interest in the baby. She may have thoughts of hurting herself or the baby. Very rarely, new mothers develop something even more serious. They may have hallucinations or try to hurt themselves or the baby. They need to get treatment right away, often in the hospital.

Postpartum depression can begin anytime within the first year after childbirth. The cause is not known. Hormonal and physical changes after birth and the stress of caring for a new baby may play a role. Women who have had depression are at higher risk.

Encourage patients to talk to you or other healthcare providers if they have postpartum depression. Medicines, including antidepressants and talk therapy, can help them get well.

Source:
www.nlm.nih.gov/medlineplus/postpartumdepression.html

Resources:

www.womenshealth.gov/publications/our-publications/fact-sheet/depression-pregnancy.html;
www.familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression.printerview.all.html;
www.acog.org/-/media/For-Patients/faq091.pdf?dmc=1&ts=20150812T1020002101;
www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml.

Rheumatoid Arthritis Management

It is estimated that 1.5 million adults have Rheumatoid Arthritis (RA) in the United States.[1] In 2009, there were 15,600 hospitalizations with RA listed as the principal diagnosis,[2] while there were 2.9 million ambulatory care visits in the United States in 2007 (2.6 million primary care visits and 1.9 million visits to a medical specialty office)[3] for management of this condition.

Individuals with RA experience more losses in function than people without arthritis in every domain of human activity, including work, leisure, and social relations.[4] Healthfirst encourages you to do the following to ensure that our members receive the appropriate care and have the best health outcomes:

- Initiate at least one Disease-Modifying Anti-rheumatic Drug (DMARD) therapy within three (3) months of an RA diagnosis for individuals 18 years or older.
- Educate your patients on how to properly take their medication, reinforce the importance of timely refills, and encourage them to notify you first if they wish to discontinue the DMARD therapy.
- Prescribe a medication that is on Healthfirst's formulary and consider the treatment with the least possible side effects to prevent noncompliance due to complications. Visit **www.healthfirst.org** to check which prescriptions are covered.
- DO NOT use RA diagnosis codes when "ruling out" the disease, but DO document the symptoms.
- Confirm that the patient DOES NOT have osteoarthritis or any another musculoskeletal condition prior to submitting a claim/encounter with an RA diagnosis code. *(Note: Claims can be corrected if a patient is misdiagnosed or if a claim is miscoded.)*
- Make referrals to in-network rheumatologists, physiatrists, and therapists to assist with your complex patients. Call **Healthfirst Provider Services at 1-888-801-1660**, Monday to Friday, 9am to 5pm, for further assistance.
- Contact the **Healthfirst Spectrum Case Management Program at 1-866-237-0997**, Monday to Friday, 8am to 6pm, if your patient requires care coordination or case management support.

For more information about RA clinical guidelines, please visit **www.rheumatology.org/Practice-Quality/Clinical-Support/Clinical-Practice-Guidelines/Rheumatoid-Arthritis.**

Sources:

[1] Sacks JJ, Luo YH, Helmick CG. Prevalence of specific types of arthritis and other rheumatic conditions in the ambulatory health care system in the United States, 2001–2005. Arthritis Care Res (Hoboken). 2010 Apr;62(4):460–4.

[2] Agency for Healthcare Quality and Research. HCUPnet. National and regional estimates on hospital use for all patients from the HCUP Nationwide Inpatient Sample (NIS). National statistics — principal procedure only. ICD-9-CM 714.0–714.9. 2011 [cited 2011 May 2011]; available from: **http://hcupnet.ahrq.gov/HCUPnet.jsp**.

[3] Schappert SM, Rechtsteiner EA. Ambulatory medical care utilization estimates for 2007. Vital Health Stat 13. 2011 Apr(169):1–38.

[4] Yelin E, Lubeck D, Holman H, Epstein W. The impact of rheumatoid arthritis and osteoarthritis: the activities of patients with rheumatoid arthritis and osteoarthritis compared to controls. JRheumatol. 1987;14(4):710–7.

Network Updates

Lactation Counseling Certification Requirement

In line with the guidance that the New York State Department of Health (NYSDOH) published in April 2013, all Healthfirst providers that deliver lactation counseling to breastfeeding mothers must be certified by the International Board of Lactation Consultant Examiners (IBLCE) in order to be reimbursed for these services.

Providers that bill these services (CPT codes S9445 and S9446) must submit their International Board Certified Lactation Consultant (IBCLC) certification number and certification effective dates to Healthfirst so that their profile can be updated with these credentials.

Methods for submission:

- Online demographic form on the provider portal at **www.healthfirst.org**
- Fax in request to Healthfirst Network Management at **1-646-313-4635**
- Contact your Network Management Representative

Providers may find more information on how they can become Certified Lactation Consultants by visiting the **International Board of Lactation Consultant Examiners** website at **www.iblce.org/certify**.

Healthfirst Laboratory Network

This year, Healthfirst expanded its network of participating diagnostic and specialty laboratory providers. When Healthfirst members are referred to out-of-network labs, it may result in members or providers being informed that they require testing—when in fact the tests have already been completed. This can also lead to inaccurate reporting.

This is why we want to remind providers to refer their Healthfirst members to participating labs in our network, so that data from their tests can be available to Healthfirst for our care management or quality programs.

A complete list of Healthfirst participating laboratories and drawing stations can be found in the online Provider Directory at **www.hfdocfinder.org**.

Social Adult Day Care Centers Must Complete Annual Certification

As of May 8, 2015, all Social Adult Day Care centers in New York State are required to complete certification each year by June 30. Once your certification is complete, you may visit **www.hfsadc.org** to attach the approval and submit it along with your contact information so we can record that you have met this requirement. If you have not yet completed certification or would like more information on this requirement, please visit the New York State Office of Medicaid Inspector General website at **www.omig.ny.gov/sadc-certification**.

New PCP Change Form

Healthfirst is pleased to announce a new, easy way for members to change their Primary Care Provider (PCP) directly from the desired provider's office. When a Healthfirst member who would like to have you as their PCP visits, you can now have the member complete and sign the PCP Change form right in your office.

Previously, the provider's office had to call Healthfirst Member Services in the member's presence to request a PCP change, or members had to call from the office themselves on their cellphone. With the new PCP Change form, providers (or members) need only fax the signed and completed form to Healthfirst at **1-212-497-8998**. This fax number is also listed on the form for reference. PCP Change forms received by 5pm will be processed by the next business day.

The PCP Change form is available on our website at **www.healthfirst.org/providerforms** and can be downloaded at any time.

We hope this new option will serve to expedite the PCP Change request process, making it easier for both our providers and members.

FIDA Training Reminder

Reminder: Participating providers in the FIDA demonstration are required to complete training on a number of key topics. These topics review important information on FIDA, with a focus on the special needs of this vulnerable population, and a goal of ensuring the delivery of quality care to FIDA participants.

All physicians, nurse practitioners, physician assistants, and other practitioners and providers who are normally credentialed by the FIDA plans and are responsible for the care of FIDA participants must take the training. The clinical leadership and compliance/administrative staff responsible in the organization are also required to take the FIDA training. **Any member of the IDT team must complete the training**. This training is available online at **https://fida.resourcesforintegratedcare.com.** Once providers complete this online training, they will meet the training requirement for all FIDA participating plans.

Since it may be difficult for some organizations to ensure that all their providers take the online modules, a downloadable training process has been developed as an alternative. Providers can access PDF versions of the FIDA training modules at the following website: **www.resourcesforintegratedcare.com/FIDA_Downloadable_Provider_Training**.

Healthfirst Members Now Get Calls About Authorization Approvals

As of August 13, 2015, Healthfirst has started to notify your patients enrolled in Healthfirst PHSP (Medicaid) and Leaf Plans (Qualified Health Plans) through automated interactive voice response (IVR) phone calls when their authorization requests are approved.

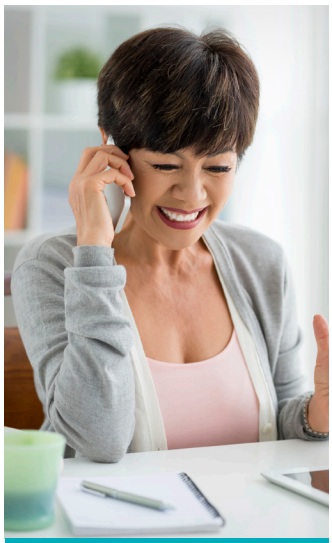
These members were previously notified about prior authorization approvals by mail only, and they will continue to get these letters in addition to the new automated calls. These members already receive live calls about authorizations that are denied.

This change will not affect how providers are notified of prior authorization approvals. Healthfirst will continue to contact you by phone about all authorizations.

Here are the key facts about the new automated authorization approval phone calls:

- Only Healthfirst PHSP and Leaf Plan members will receive the IVR calls about their authorization approvals
- These members have already been notified by a phone call about denials
- The automated calls give the provider name, service name, and authorization start and end dates, and refer the member to Healthfirst Member Services for more information
- The calls are given in English, Spanish, or Mandarin, depending on the member's preferred language

If you provide services that require prior authorization, please note that your patients will now know sooner that Healthfirst has approved these services. These members may be more proactive about following up with you about the approved services.



As a reminder, please remember to obtain prior authorization before directing members to out-of-network providers. This is important to ensuring a positive member experience.

healthfirst®
P.O. Box 5168, New York, NY 10274-5168

TheSource

Healthfirst welcomes Touchstone members.
If your patient asks about Healthfirst, please ask them to call 1-844-588-3581.